Current V-BID Landscape in Connecticut
Summary Report [DRAFT]

EXECUTIVE SUMMARY

Freedman HealthCare (FHC) in partnership with VBID Health and Bruce Landon, is pleased to present this report of findings to the State Innovation Model (SIM) Connecticut Program Management Office (PMO) and the Office of the State Comptroller on the current status of value-based insurance design (V-BID) in the Connecticut market. This report will guide recommendations for further promoting V-BID in the Connecticut marketplace, and will assist in the development of communications materials and strategic guidance for Connecticut employers to develop comprehensive V-BID plans that promote healthy, cost-effective choices among employees.

FHC has conducted a survey of V-BID health plans in Connecticut and nationally through interviews with employers, health plans, and employer associations, and a review of existing literature on V-BID. For the purposes of this initiative, V-BID is defined as plans that utilize clinical nuance, meaning that the clinical benefit derived from a specific service depends on the patients using it, as well as when, where, and by whom the service is provided.

This survey found the following opportunities for V-BID promotion:

- Connecticut is a leader in implementing clinically nuanced plan design in the self-insured market through the State's Health Enhancement Program (HEP) for State employees.
- Connecticut is home to many V-BID early adopters and innovative leaders, including HEP, Pitney Bowes, and ConnectiCare, each of whom have successfully implemented V-BID concepts into employee health plans, presenting an opportunity to share lessons learned and provide guidance to other employers.

While Connecticut is a leader in insurance innovation, the survey did reveal several challenges to increasing V-BID uptake among employers in Connecticut:

- Many employers in Connecticut do not know what V-BID health plans are, and as such they are not demanding these products from health insurance carriers.
- Health insurance carriers have vastly different definitions of V-BID, which can make it difficult to assess the degree of implementation across payers.
- Few health insurance carriers currently employ clinical nuance in their commercial employer plans, the major exceptions being ConnectiCare and the State's Health Enhancement Program (HEP).

In spite of these barriers, it is clear that Connecticut has great potential for V-BID plan adoption, which will be fostered through stakeholder engagement in the V-BID Consortium and Learning Collaborative established by the PMO and OSC. Informed by this assessment, these groups will help identify and disseminate best practices for V-BID promotion and implementation among self and fully insured employers in the State.

BACKGROUND

Value-based insurance design (V-BID) refers to insurance plans that utilize clinical nuance in realigning consumer incentives with high value health services. Clinical nuance recognizes that medical services differ in the benefit provided, and that the clinical benefit derived from a specific service depends on the patients using it, as well as when, where, and by whom the service is provided. The aim of V-BID is to increase healthcare quality and to decrease costs by using differential cost sharing for consumers to promote use of high value services and high performing providers, and decrease use of low value services and low performing providers. V-BID plans target specific services and populations to align patients' out-of-pocket costs, such as copayments and deductibles, with the value of services.

Drs. Mark Fendrick and Michael Chernew first coined the term "value based insurance design" in 2001. Since then, V-BID has received national attention and has been implemented to some degree by major employers such as Marriott International, LaFarge North America, and Pitney Bowes, as well as city and state governments. The Affordable Care Act (ACA) nationalized a V-BID principle in requiring all health plans to include certain preventive services without any patient copayments. More recently, the Centers for Medicare & Medicaid Services (CMS) has announced an initiative to pilot Value-Based Insurance Design in Medicare Advantage plans in seven states, beginning in January 2017. Medicare Advantage plans in these states will offer clinically nuanced benefit designs for enrollees with certain chronic conditions, including diabetes, COPD, congestive heart failure, hypertension, and mood disorders.

Notably, Connecticut has led the nation in its successful 2011 implementation of the Health Enhancement Program (HEP), a V-BID program offered to state employees. HEP is a voluntary program for all employees, retirees, and dependents that requires enrollees to comply with a minimum schedule of wellness exams and screenings, and participate in disease counseling and education specific to their condition (if applicable). Participants in HEP who comply with these conditions are eligible for reduced or waived copayments and other benefits, whereas those who do not enroll or are removed for noncompliance pay an extra $100 per month in premiums. Employee participation is close to 98% and of those enrolled there is a 99% compliance rate with the conditions of the program[1].

The success of HEP has distinguished Connecticut as a leader in the field of value-based insurance. Building upon its success, the State Innovation Model (SIM) Program Management Office (PMO) has pursued an ambitious plan to increase adoption of efficient, value-centered V-BID programs among Connecticut employers, with the goal of reaching 88% V-BID adoption by 2020 as part of the SIM program. To achieve its goal of a whole-person-center healthcare system, the PMO launched the Value Based Insurance Design Initiative, which aims to increase uptake of V-BID in Connecticut by developing a V-BID prototype of recommended practices and plans, with strategies and tools to select and promote V-BID plans.

To this end, the PMO has engaged Freedman HealthCare (FHC) along with its partners VBID Health and Bruce Landon, to review the Connecticut health insurance landscape and to assess the degree to which value-based insurance design has already been implemented among health plans and employers in Connecticut. This report summarizes FHC's findings based on stakeholder interviews with health plans,

[1] "V-BID in Action: A Profile of Connecticut's Health Enhancement Program." *University of Michigan Center for Value-Based Insurance Design*. Jan. 2013.

the employer community, and research of existing V-BID plans. FHC spoke with representatives from employer groups and leading health plans in the state, including Aetna, Anthem, ConnectiCare, Healthy CT, Harvard Pilgrim, and United HealthCare. This report reviews the varying criteria and components of value based insurance design, the degree to which Connecticut health insurers and employers are providing these benefits, and the features of existing health plans that could be adapted towards a value-based design.

VALUE-BASED DIFFERENTIAL COST SHARING FOR SERVICES AND DRUGS

Out-of-pocket costs continue to be a major barrier to accessing healthcare services in Connecticut and nationwide, and most adversely affect those with chronic diseases who require more services. Reducing or waiving the copays for high-value services and drugs, including preventive care not already covered through the ACA, can encourage healthy patient choices and the use of high-value, evidence based treatment, particularly if applied in a clinically nuanced manner.

Decreased Cost Sharing for High Value Drugs and Services

Pitney Bowes, a Connecticut-based employer, implemented this value-based solution for its employees through a prescription drug program in 2001 that was the first of its kind in the nation. Facing increasing healthcare costs, Pitney Bowes changed its pharmacy plan for enrollees with a select group of chronic conditions: asthma, hypertension and diabetes. Pitney Bowes reduced the copays for these groups' brand-name medications (at the time, the medications for these conditions were all-brand name) to the same levels as the copays for generic medications[2]. This reduction in cost-sharing led to greater adherence, and better long-term health and cost savings for Pitney Bowes. In 2007, Pitney Bowes again led the field in V-BID implementation by eliminating copayments for cholesterol-lowering statins for its employees and beneficiaries with diabetes or vascular disease and lowered copays for all employees and beneficiaries prescribed the clot-inhibiting drug clopidogrel[3]. Again, the decreased copay resulted in increased adherence and increased cost savings for Pitney Bowes. This is a prime example of how aligning incentives with high value services can both save money and promote healthier behaviors.

Increased Cost Sharing for Low Value Drugs and Services

A model V-BID plan may also make use of disincentives to promote use of high value care. These so-called "sticks" would apply a penalty, such as an increased premium rate or increased copay, for the use of low value services or non-adherence with a disease management program. This lever is the most under-utilized tool in value-based insurance in Connecticut. Employers are concerned about the potential backlash both from raising employee costs in certain circumstances and of inadvertently penalizing employees who may not fully understand the details of their health benefits. Employers' return on investment with V-BID will be harder to achieve in the absence of any increased cost sharing for low value services.

[2] "Reducing Patient Drug Acquisition Costs Can Lower Diabetes Health Claims." Mahoney, John J. *The American Journal of Managed Care*. Aug. 2005

[3] "At Pitney Bowes, Value-Based Insurance Design Cut Copayments And Increased Drug Adherence." Choudry, Niteesh K., Fischer, Avorn, et al. *HealthAffairs*. Nov. 2010

Importantly, HEP has successfully utilized penalties in its value-based design. Perhaps one of the most important components of HEP is that it is voluntary, and as such enrollees must agree to meet the conditions of the program before receiving the benefits. This provides a key access point to educate enrollees on the benefits, penalties, and conditions of the program. If an enrollee is non-adherent, they are dropped from the program and their premium rates are increased. Given that HEP has a 99% compliance rate, it is clear that the penalty works effectively with the rest of the plan in promoting the use of high value care. What is unclear is how this model could effectively be adapted to the commercial market, particularly the fully insured market.

With HEP and Pitney Bowes, Connecticut is already leading the way in experimenting with clinically nuanced incentives for high value healthcare services and drugs. Pitney Bowes is one of the most oft-cited studies in the relationship between reduced cost-sharing and patient adherence, and HEP is one of the most comprehensive and successful V-BID programs in the nation. Nevertheless, few employers and health plans in Connecticut are currently reducing cost-sharing for high-value services in a clinically nuanced manner, although some are exploring V-BID options One health plan is currently exploring possibilities for eliminating copays for their own employees suffering from diabetes and depression when they visit a relevant specialist. Another health plan noted that while they do provide some large employers with clinically nuanced plans (reducing copays for office visits and pharmaceuticals for enrollees with chronic diseases) these plans make up less than 1% of their market.

VALUE-BASED DIFFERENTIAL COST SHARING FOR PROVIDERS

Another approach to value based insurance design is to encourage the use of high value providers through differential copayments or deductibles. To pursue this, health plans or employer groups must determine which providers are "high performing". Many health plans in Connecticut have already developed systems for rating providers for their current health care products, however these are not standardized across plans. The Connecticut SIM office is in the process of developing a Common Provider Scorecard which could assist in aligning provider quality ratings across payers. Many health plans noted concern over straining relationships between payers and providers, therefore, having consistent, state-wide quality metrics through the SIM may alleviate some of this tension.

In Connecticut, health care plans, including Aetna and United HealthCare, have been experimenting with tiered networks in which employers benefit from a discount in premiums and consumers are incentivized with lower copays to seek services at high value providers. Unlike a narrow network, in which providers out-of-network are cut out of benefit plans, tiered network physicians are ranked, and consumers are charged less for visiting providers in the highest tier.

Aetna Whole Health uses a steeply tiered network that helps to contain costs and pushes consumers to participate in their Connecticut Preferred Health Network (Tier 1). There is a 20% benefit differential between Tier 1 and Tier 2 providers (except for preventive care which is covered 100%)[4]. Tier 2 includes Aetna's national network of providers, where a standard deductible applies, and Tier 3 includes out-of-

[4] "2015 Connecticut Plan Guide for Business with 51-100 eligible employees." Web. March 11, 2016. www.aetna.com/employer-plans/

network providers. Although this model uses differential cost sharing to drive consumers towards higher-value providers, it does not incorporate clinical nuance. Aetna, like other health plans, uses a broader definition of value-based insurance design, a definition that includes any value-based payment arrangement, including Accountable Care Organizations (ACOs), Patient-Centered Medical Homes (PCMH), Pay for Performance (P4P), and Shared Savings plans. Aetna focuses most of its efforts in promoting value through ACO provider structures, rather than clinically nuanced insurance plans.

One way to apply clinical nuance into this V-BID concept would be for health plans to rate providers on their ability to manage certain chronic diseases. For example, people with diabetes may qualify for a lower copay if they receive medical care from a physician group that excels in diabetes management, regardless of the providers' overall value ratings. While tiered and narrow networks are becoming more popular among employers in Connecticut, these approaches have not yet incorporated clinical nuance into their models. Nevertheless, examples of this can be found among some prominent national employers.

General Electric has developed a program based on Centers of Excellence (COE), for its employees nationwide that encourages use of certain providers based on their outcomes for certain chronic conditions and medical procedures[5]. For instance, GE covers 100% of the medical cost (as well as travel expenses up to $2,000) of hip & knee replacements for employees who meet the clinical eligibility requirements and attend one of four COEs: Northwestern Memorial in Chicago, the Hospital for Special Surgery in New York, Carolinas Medical Center in North Carolina, and Christ Church Hospital in Ohio. GE has several COEs across the nation that can be used by employees who meet the clinical requirements set by the plan, including Obesity surgery COEs, Organ transplant COEs, and Substance Abuse COEs.

There are several reasons that employers in Connecticut have not yet adopted more clinically nuanced incentives towards high value providers, including a concern about further complicating benefit designs and straining relationships with providers who are increasingly ranked on various metrics. Connecticut employer groups have also expressed concern over limiting the provider choices for their employees, and inadvertently penalizing employees who do not understand the benefits of their health plan.

DIFFERENTIAL COST SHARING FOR PARTICIPATION IN DISEASE MANAGEMENT PROGRAMS

One of the incentives explored in this assessment was reduced cost sharing for people with chronic diseases who participate in disease management programs. These programs reward active engagement in a disease management program through reduced premiums or copays for certain services. For instance, an employer concerned about the increasing prevalence of diabetes among employees may be interested in a specific program that identifies people with diabetes and rewards (or penalizes) them if they do (or do not) engage in certain diabetes management activities.

With growing concern, employers have watched their health care costs rise along with the increasing prevalence of chronic diseases. As such, wellness programs have become a popular tool in health

[5] "Centers of Excellence (COE)". Web. March 11, 2016. http://www.ge-healthahead.com/coe?language=en&country=US

promotion, particularly in the large group market. Aetna, Anthem, ConnectiCare, Harvard Pilgrim Health Care, and United all offer a variety of wellness programs and packages for employers to choose from. While these may be value-based insurance products in a broad sense of the term, wellness programs only occasionally include the clinical nuance that the V-BID initiative is seeking to promote. Most of these wellness programs are generally applicable rather than clinically nuanced; all employees are either required or welcome to enroll in the programs by performing a Health Risk Assessment (HRA) or biometric screening, and are generally incentivized towards healthy habits (i.e. healthy diet, exercise, etc.).

One insurer does offers plans to employers that base premium rates based both on the actual taking of the biometric screening (or HRA), and the results of the screening. All enrollees who complete the screening receive a premium reduction regardless of the results. The screening results are then used to identify individuals at high risk for certain chronic conditions. Those individuals are required to meet with a health coach or participate in a relevant disease management program in order to keep the reduced premium rate. If they are not adherent, the higher premium rate is reinstated. In doing so, all enrollees have a chance at being rewarded, but the employer can identify high- risk individuals and make the reward conditional on adherence to a disease management program. This approach is an example of how plan could balance both incentives and disincentives through V-BID.

The insurer uses two different incentives for wellness programs based on the plan type. For enrollees in High Deductible Health Plans (HDHPs), employers deposit $250 directly into employees' Health Savings Account (HSA) if they perform either a health risk assessment or a biometric screening. For employees not in an HDHP, they receive a $250 credit toward their deductible. The plan found that paying $250 into the HSA is more successful at incentivizing the screenings than the $250 credit towards the deductible. This is because employees more easily appreciate incentives that directly provide cash to the employee rather than a credit against future coinsurance and deductibles.

The ubiquity of wellness programs across the state may represent a key opportunity for the growth of V-BID programs. For example, if employees are already completing HRAs or biometric screenings for these wellness programs, employers will be able to identify trends in chronic diseases and potentially intervene with chronic disease management incentives for at-risk employees.

CONCLUSIONS AND FUTURE DIRECTIONS

The findings of this report indicate that educating both employers and health plans in Connecticut on the concepts of value-based insurance design (what it is, and what it is not), as well as its advantages pertaining to both health outcomes and long term cost savings, will be crucial to achieving the goals of the V-BID initiative. Health plans frequently deferred to the lack of demand for V-BID as a chief reason for not supplying V-BID products.

Stakeholders emphasized that employers will need to understand how they will achieve short-term and long-term returns on investment, even if the short-term rewards are not financial. Employers with high turn-over rates are unlikely to adopt V-BID plans that take upwards of 3 years to recoup costs. Therefore, a successful V-BID approach will focus on educating both employers and consumers on how V-BID plans can benefit them, such as by reducing long-term costs and improving healthcare outcomes.

While the self-insured market can take many lessons learned from the successful implementation of HEP, it may be challenging to integrate VBID into fully-insured plans. However, the increasing adoption of VBID concepts in major health plans nationally, such as the Medicare Advantage initiative, provide additional models and strategies from which Connecticut insurers and employers can learn. Stakeholders emphasized the importance of VBID implementation being simple to understand and flexible enough to be adapted into various plan designs. The V-BID initiative and prototype should build on existing value-based health care structures in the state. A successful V-BID plan should work within the system of ACOs, tiered networks, HDHPs, and employee wellness plans that currently shape the Connecticut landscape.

APPENDIX: SWOT Analysis of V-BID Uptake in Connecticut

Please Note: These findings are general themes drawn from various conversations with stakeholders in the State. As such, these findings are subjective in nature and we recognize that there may be some disagreement on the conclusions.

	Strengths Specific to Connecticut	**Stakeholder**	**Recommendations**	**Discussion Questions**
Internal to CT Stakeholder Team	CT citizens show a willingness to engage and an interest in understanding new insurance options and consumer advocacy groups are very active.	Consumers, Employers	Engage consumer groups, such as unions, in the Learning Collaborative and educate them to become strong VBID champions for employees and consumers.	How are employees/consumers best engaged?
	HEP is the leading national model for the self-insured VBID market.	Health Plans	Apply HEP's model to other self-insured employers and modify it for other market segments.	Are there concepts from HEP that should definitely be adopted? Not be adopted?
	The CT SIM includes a Quality Measure Alignment initiative.	Providers	Leverage the Quality Measure Alignment efforts (i.e. Common Provider Scorecard) of the SIM Initiative to help identify and promote high-value providers.	How do we define a high value provider? Is this the role of the Consortium? Should we aim for statewide quality ratings or allow individual health plans to use their own ratings?
	Some health plans have already begun defining high value providers and establishing structures to incentivize consumers towards these providers (e.g. provider ratings, tiered networks and ACO structures).	Health Plans	Align cost sharing for high value providers as part of VBID plans with existing tiered networks and ACO structures.	Do we need to align with these tiered networks? How can tiers be made "clinically nuanced", i.e. specific providers are incentivized for certain patient populations? How can we merge different definitions of "high value" providers?
	Patients are being driven towards high value primary care providers, a trend that aligns provider and patient incentives.	Health plans, Employers	Incorporate incentive structure to drive members towards using high value PCPs as part of VBID template.	How do we address plans that utilize PPOs where members are not required to choose PCP?
	Weaknesses Specific to Connecticut	**Stakeholder**	**Recommendations**	**Discussion Questions**
	Some employers may be hesitant to increase cost-sharing for employees or apply "sticks"; this may affect short-term ROI, as VBID will be costly in the first few years without OOP increases	Employers, Consumers	Encourage implementation of balanced incentives over time, as employees get acclimated to differential cost sharing.	Do we pursue increased cost sharing for low-value services? Could an increase in cost sharing be implemented on the provider side instead of the consumer side? How do we engage consumers/unions and garner support for increased cost sharing?
	Some employers are more interested in immediate cost-reduction, especially those with high turnover rates, and may give up VBID if they do not see ROI in the first year.	Employers	Emphasize short-term non-financial benefits to employers and predicted long-term cost reductions from HEP evaluations (and other VBID plans if available).	

	There is no state mandate for participation in V-BID, which could produce adverse selection by driving patients with chronic diseases towards these plans.	Health Plans	Provide some incentives for all members in VBID template to drive healthy employees towards plan.	Do we consider pushing for a state mandate? How can we encourage employers to only offer V-BID options to combat adverse selection?
	Connecticut's regulatory environment presents challenges for offering clinically-nuanced differential cost sharing in plan designs.	Health Plans, Employers, DOI	Use the more flexible self-insured plan designs as a model, and explore options for building differential cost sharing through a care management approach.	How can we modify the regulatory environment?
	It may be difficult to engage the small-group, fully-insured market in VBID plan adoption.	Health Plans, Employers	Engage fully insured employers in the Learning Collaborative to encourage demand for VBID among this market	How do we identify employers from the fully insured market for the Learning Collaborative?
	There are limited examples of clinical nuance in the CT commercial market.	All	Provide a "transition plan" in the toolkit to assist employers in avoiding pitfalls.	
	There is little demand for VBID from the employer market, limiting plans' incentives to offer it.	Employers	Leverage the Learning Collaborative to build demand for VBID among employers. Encourage the Exchange to adopt a VBID plan, which may encourage other plans to offer a similar product. Market at business groups annual meetings (CBID, CTBGH, NEBGH) to get employers interested in V-BID and joining the collaborative.	What other ways can we raise awareness and interest among business groups and employers about the Learning Collaborative?
External to CT Stakeholder Team	**<u>Opportunities</u> for VBID**	**Stakeholder**	**Recommendations**	**Discussion Questions**
	Health care costs are rising in the state and nationally, so employers and plans are looking for innovative ways to curb costs and improve outcomes.	All	Provide examples of how VBID aligns with these goals in the Tool kit and employer communications materials.	
	Employers are interested in targeting patients with chronic conditions as a way to reduce costs.	Employers	Design incentive structure to target people with costly and multiple chronic conditions in the VBID template. Consider chronic diseases that are targeted by the Quality Council and part of the Core Quality Measure Set.	Which chronic conditions should be targeted?
	HSA-eligible High Deductible Health Plans are becoming more common.	All	Leverage consumers' increased awareness of the cost of services by identifying strategies for implementing VBID as part of HDHP-HSAs.	How can VBID be implemented as part of HDHP HSA? Can we see a path forward to gradually transition from HDHP towards V-BID with disincentives/penalties?
	The large employer and self-insured markets have more flexibility in plan design and could more easily adopt clinical nuance.	Employers	Use the self-insured market template as the "ideal" template for VBID uptake. Can leverage self-insured market as testing ground for VBID strategies.	

	VBID adoption is growing among innovative employers and with the introduction of the Medicare Advantage model.	Employers	Leverage Medicare Advantage as the national model to drive VBID adoption among commercial insurers.	
	The market may be primed for progressing towards clinical nuance and design innovation, as the ACA already requires plans to implement some differential cost sharing for high value services across all plans (i.e. preventive drug coverage).	Health Plans	Market VBID as a competitive edge for plans by promoting a clinically nuanced incentive structure to get better outcomes and higher ROI.	How would VBID offerings to all members be different from ACA requirements?
	<u>Threats</u> for VBID	**Stakeholder**	**Recommendations**	**Discussion Questions**
	Health plans and employers are wary of the administrative burden of implementing clinical nuance.	Health Plans	Engage Consortium health plan and employer members in strategies to reduce administrative burden when designing VBID template.	What are strategies to simplify administration of VBID plans that are clinically nuanced? Can HIE or edge server play an enabling role?
	Consumer advocacy groups are very active and may push back on perceived "discriminatory benefits," even if educated on VBID.	Consumers	Engage key consumers (e.g. union groups) in the Learning Collaborative to increase their understanding and buy-in.	
	Patients may not understand the differences between low value and high value services, or how differential cost sharing is applied, which may limit the effectiveness of incentives and disincentives.	Consumers	Keep plans relatively simple, and emphasize in employer materials the importance of employers' communication to their employees about the plan. Engage union and other employee leaders to educate employees.	
	Some health plans that have clinically nuanced VBID components have been discontinued or represent a small share of the market due to lack of market demand.	Health plans	Demonstrate the effectiveness of VBID through evaluations that show success (such as HEP).	
	There has been a rise in employee wellness plans, which are not necessarily clinically nuanced or evidence-based, and are often mistaken for VBID.	Health plans, Employers	Address the difference between clinical nuance and employee wellness plans in template and employer communication materials.	Do employee wellness plans have any place in VBID template? How do we ensure employers know the difference between wellness plans and VBID? How can we build upon existing wellness programs to incorporate clinical nuance?
	This is an election year; efforts to promote VBID may be thwarted based on the outcome of the election (i.e. if the ACA is repealed).	All	Consider crafting a Plan B to move forward with promoting V-BID in the event of a major change in health care law.	
	There has been an increase in HSA-eligible High Deductible Health Plans, which do not cover secondary preventive services for chronic diseases under the HSA and require patients to meet high deductibles first.	All	Adopt innovative designs for HSA-eligible HDHPs, such as the employer contributing to the HSA for utilizing certain preventive services.	With increasing HDHPs, how do we reduce cost sharing on high value services not covered by the HSA preventive services safe harbor?